

Investigating “mass hysteria” in early postcolonial Uganda: Benjamin H. Kagwa, East African psychiatry, and the Gisu

Abstract

In the early 1960s, medical officers and administrators began to receive reports of what was being described as “mass madness” and “mass hysteria” in Tanganyika (now Tanzania) and Uganda. Each epidemic reportedly affected between 300 and 600 people and, coming in the wake of independence from colonial rule, caused considerable concern. One of the practitioners sent to investigate was Benjamin H. Kagwa, a Ugandan-born psychiatrist whose report represents the first investigation by an African psychiatrist in East Africa. This article uses Kagwa’s investigation to explore some of the difficulties facing East Africa’s first generation of psychiatrists as they took over responsibility for psychiatry. During this period, psychiatrists worked in an intellectual climate that was both attempting to deal with the legacy of colonial racism, and which placed faith in African psychiatrists to reveal more culturally sensitive insights into African psychopathology. The epidemics were the first major challenge for psychiatrists such as Kagwa precisely because they appeared to confirm what colonial psychiatrists had been warning for years—that westernization would eventually result in mass mental instability. As this article argues, however, Kagwa was never fully able to free himself from the practices and assumptions that had pervaded his discipline under colonial rule. His analysis of the epidemics as a “mental conflict” fit into a much longer tradition of psychiatry in East Africa, and stood starkly against the explanations of the local community.

Keywords: Uganda, Hysteria, Psychiatry, Traditional Medicine, Africanization, Epidemics

In the early 1960s, medical officers and administrators in Uganda and Tanganyika (now Tanzania) began to receive reports of what was being described as “mass madness” and “mass hysteria” in areas around Lake Victoria. Starting with a case of “laughing mania” at Bukoba, north-west Tanganyika, in 1962, further reports of “running manias associated with violence” followed in 1963 in Kigezi, south-west Uganda, and Mbale, eastern Uganda. Faced with reports of up to six hundred “victims” in each area, the local authorities were at a loss as to how to respond. While they had well-established measures in place for investigating and preventing the spread of infectious diseases such as cerebro-spinal meningitis, there were no guidelines dictating the proper procedure for a psychic epidemic. As one account in the *New York Times* noted: “Near Bukoba an entire village of more than 200 persons fell ill in a matter of days....To villagers with tears in the eyes from fits of hysteria, the disease is “endwara ya Kucheka”—the laughing trouble. To doctors, it is one of Africa’s newest and most puzzling illnesses”.ⁱ

At the request of the Ugandan and Tanganyikan Governments, two different teams investigated the epidemics. The first, led by A.M. Rankin, Professor of Medicine at Makerere University College, Uganda, along with P.J. Philip, a Medical Officer for the Tanganyikan Government, focused on Bukoba. They conducted a series of laboratory tests to rule out organic causes for the disorder, before reaching a tentative diagnosis of mass hysteria by process of elimination.ⁱⁱ The second investigation was based at Mbale and led by Benjamin H. Kagwa, a Ugandan-born psychiatrist who had just returned to Uganda after living and working in the United States for over fifteen years.ⁱⁱⁱ Kagwa conducted a series of neuropsychiatric tests, analysing his findings alongside historical examples of mass hysteria from sixteenth-century Europe and long-held theories about the inferior nature of “the African mind.” He showed little interest in local explanations for the madness, which linked it to the anger of ancestral spirits.^{iv} Instead, Kagwa stressed that the epidemics, coming in the

wake of independence from colonial rule, provided evidence that East Africans were suffering from a “mental conflict” brought on by education and “westernization.”^v

Kagwa’s paper, published in the *East African Medical Journal (EAMJ)* in 1964, represents the first scientific investigation by an indigenous-born psychiatrist in East Africa. That the paper was written by a Ugandan should come as no surprise—at Independence in 1962, Uganda, with its long tradition of promoting medical education, was in the strongest position of the three East African countries to take over control of colonial medical institutions.^{vi} Kenya and Tanganyika, by contrast, had relatively few western-trained African doctors and no indigenous-born psychiatrists by the time they gained independence in 1963 and 1961 respectively. Starting with Kagwa, psychiatry in Uganda would eventually develop into a significant intellectual tradition, gaining international recognition in the early 1970s for its research and training programmes.

The history of psychiatry in Africa has been the subject of a small but growing area of inquiry for historians over the last thirty years.^{vii} Until very recently, historians have focused overwhelmingly on the colonial period, using psychiatry as a way of shedding light on broader aspects of colonial rule.^{viii} In East Africa, this literature has been dominated by Kenya and the “East African School” of psychiatry and psychology.^{ix} Between the 1920s and 1950s, as historians such as Megan Vaughan, Gail Beuschel, and Sloan Mahone have shown, a body of research on African intellect, personality traits and psychopathology grew in the pages of the *EAMJ* and in discussions at local branch meetings of the British Medical Association (BMA).^x Research on “the African mind,” as it became known, stressed biological and cultural differences between Africans and Europeans, and was particularly noted for its practical implications for colonial rule. The failure of African cultures to incorporate the traits of individual control, abstract thought, and personal responsibility, it

was theorised, meant that “westernization” or “detribalization” was particularly dangerous for Africans, and required the immediate extension of “social protection and control.”^{xi}

By the early 1960s, these theories had started to fall out of fashion as the growing discipline of transcultural psychiatry urged researchers to be more sensitive to the ways in which mental illness was shaped by culture. While it has been noted that this ideological shift brought an end to the East African School, as well as ethnopsychiatry more generally, the dynamics of the ways in which psychiatry continued to operate into the postcolonial period have yet to be explored in East Africa. Indeed, perhaps because the links between psychiatry and colonial power have been so compelling, historians of psychiatry in Africa have generally been slower to move into the postcolonial period than historians of other medical disciplines.^{xii} The exceptions come from West Africa, where historians such as Alice Bullard, Matthew Heaton, and Richard Keller have argued that psychiatry was transformed as expatriate and indigenous-born psychiatrists attempted to free themselves from the weight of colonial racism and became more open to collaborations with traditional healers.^{xiii} According to Heaton, Thomas Adeoye Lambo, Nigeria’s first indigenous-born, western-trained psychiatrist, was crucial to the decolonization of psychiatry across Africa, being “instrumental in changing attitudes about the relationship between race, culture and mental disorder.”^{xiv}

This article takes up and extends these themes in an East African context. In Uganda, the first generation of African psychiatrists not only had to negotiate the legacies of colonial racism and the underdevelopment of psychiatric institutions, but the vehemence of the theories and personalities of the East African School. The epidemics of mass hysteria of the early 1960s were the first major challenge for psychiatrists such as Kagwa precisely because they appeared to confirm what the East African School had been warning for years—namely, that westernization and detribalization would eventually result in mass mental instability. As

this article argues, however, Kagwa was never fully able to free himself from the practices and assumptions that had pervaded his discipline under colonial rule. His analysis of the epidemics as a “mental conflict” linked to education and westernization fit into a much longer tradition of psychiatry in East Africa, and stood starkly against the explanations of the local community.

In exploring the epidemics of mass hysteria, the article draws on four main types of sources: the papers published by Kagwa, Rankin, and Philip; articles published in the *EAMJ*, founded as the *Kenya Medical Journal* in 1923 and the main voice for the scientific community in East Africa; materials found in district archives in Uganda; and oral histories conducted with eighteen Gisu elders, an ethnic group located in the area surrounding Mount Elgon, near Mbale, Uganda. Uganda’s district archives, which comprise of the administrative files kept by former District Commissioners (now Chief Administrative Officers), have recently been made more accessible to researchers, prompting renewed interest in Ugandan history in the colonial and postcolonial periods.^{xv} For those with the time and patience to sort through uncatalogued boxes, in often physically challenging working conditions, these archives offer a treasure trove for historians of medicine.^{xvi} While the extent of each collection varies, files can be found on such topics as health education, infectious disease control, hospital complaints, mental illness and witchcraft, rural dispensaries, and traditional healers.^{xvii} As only a small amount of material was found to relate directly to the epidemics of mass hysteria, records from district archives are used in this article primarily to contextualise the themes and stories that emerged from the oral histories.

The epidemics of mass hysteria were significant enough to be remembered by people living in eastern Uganda in 2011 as a “disease of that time,” and focused enough for Gisu elders to share their fears, anxieties, and experiences of a specific event in interviews.^{xviii} Contacts were made over a period of a few months with the assistance of the Joint Clinical

Research Centre (JCRC), Mbale. With the aid of a translator, the purpose of the project and their involvement was explained, and oral consent was obtained. The interviews were strongly influenced by Marjorie Shostak, whose work among *!Kung* women in Botswana highlighted the strengths of aiming “to elicit specific incidents rather than generalized statements.” “Discreet memories,” as Shostak asserted, “were more likely to capture the texture of the women’s experiences and to highlight the variations among the different women in their life stories and in their interpretations of these stories.”^{xix} While some of the nuances of the experiences of those who lived through the epidemics in eastern Uganda have undoubtedly been lost in the translation process, the focus on individual cases of mental illness—whether in a family member or neighbour—nevertheless offers a rare opportunity to interrogate the nature of early postcolonial psychiatry by incorporating the voices of both psychiatrists and patients into the analysis.

This article is not intended to be a comprehensive account of the work of East Africa’s first indigenous-born psychiatrists. Nor does it aim to trace all of the continuities and distinctions between colonial and early postcolonial psychiatry. Rather, it uses the epidemics of mass hysteria in the early 1960s as a way of illuminating some of the difficulties facing East Africa’s first generation of psychiatrists as they took over responsibility for mental health care. While the investigation undertaken by the European medical practitioners, Rankin and Philip, is also considered, the main focus of the article is on Kagwa and the Gisu ethnic group of eastern Uganda. Not only did Kagwa’s paper make claims about the state of the East African psyche that went well beyond the tentative diagnosis of mass hysteria made by Rankin and Philip, but he attempted to bring specialist psychiatric techniques to the diagnosis and treatment of patients. As shall see in the first two sections of this article, Kagwa was working in an intellectual climate that was both attempting to deal with the legacy of the East African School of psychiatry and psychology, and which placed faith in

African psychiatrists to bring new and more culturally sensitive insights into African psychopathology.

The “East African School” and mass mental instability

The idea that Africans were prone to periodic outbursts of mass mental instability had been present in the ethnographic literature since the beginning of the colonial period. In Kenya, ethnologists such as Gerhard Lindblom described how “psychical disturbances of a religious character pass like epidemics over the Kamba country.”^{xx} These disturbances, known locally as *kijesu*, were categorised variously as “infectious hysteria” or “epidemic mania,” and were given a distinctly political tone—in one town, according to Lindblom, people went into convulsions at the mere sight of a European.^{xxi} In Uganda, too, the belief that Africans were highly “suggestible” underpinned accounts of the *Nyabingi* movement in the south-west. Characterized by contemporary observers as anti-colonial “secret society” or “cult,”^{xxii} followers of *Nyabingi*, a fertility goddess, were portrayed as being under the influence of witchcraft on a vast scale. As the District Commissioner for Kigezi, Captain J.E.T. Philipps, stressed in 1919, *Nyabingi* practices were spreading “by means of an unusually developed form of Witchcraft, in which hypnotic suggestion plays a leading part, the country within the sphere of its operations is completely terrorised.”^{xxiii} Such accounts formed part of a broader attempt to describe and define what constituted “normal” and “abnormal” behaviour. Infusing their work with notions of European racial and cultural superiority, authors dismissed indigenous cultural practices as evidence of psychopathology. Such was the power of traditional beliefs, it was said, that Africans could will themselves to die.^{xxiv}

The epidemic nature of these disturbances was particularly worrying for colonial administrators: if unchecked, as Mahone has argued, mass instability had the potential to

spread and destabilize whole regions.^{xxv} These fears were reinforced from the 1930s as scientific communities in Africa started to discuss how contact with western civilization could “detritalize” the African and trigger a particularly “European” type of insanity, characterized by delusions of power and control.^{xxvi} Within East Africa, these ideas achieved coherence in the pages of the *EAMJ*, where psychiatrists and psychologists set out their theories on African thought processes, personality types, and behaviors. While there was some disagreement about the role of race and culture in either predisposing Africans to mental illness or in providing a form of “psychotic immunity,” all of the research was guided by the assumption that western civilization was dangerous for “primitive minds.” This body of literature would later come to be known as the East African School of psychiatry and psychology, achieving infamy in the 1950s for the vociferous arguments of J.C. Carothers about “the African mind.”

Henry L. Gordon, Visiting Physician to Mathari Mental Hospital, Kenya, 1930-1937, was one of the earliest physicians associated with the East African School. A committed eugenicist, Gordon’s research was concerned primarily with explaining what he regarded as inferior levels of intelligence in Africans through brain size and growth.^{xxvii} In his writings on mental illness, civilization—the main vehicle for which was education—presented Africans with stresses and strains that they were unable to manage because of their underdeveloped brain structures. As Gordon noted in the *EAMJ* in 1936, the “pressure of thought, emotion, behaviour; of intellect, imagination, foresight,” all formed “an unprecedented experience for the Native brain involving inevitable adjustment or inevitable catastrophe.”^{xxviii} While Gordon never referred specifically to the threat of mass hysteria, he was pessimistic about the ability of Africans to cope with the speed of change under colonial rule. Referring to the introduction of educational cinema into Tanganyika in the mid-1930s, Gordon quipped that it

could be that medical practitioners would soon have to deal with such conditions as “Bantu confusional cinema psychosis.”^{xxxix}

Gordon was followed at Mathari by J.C. Carothers, a South African-born psychiatrist who had trained in the United Kingdom.^{xxx} While Carothers moved away from Gordon insofar as he emphasized the importance of cultural, as opposed to biological difference, he also maintained that mental derangement would become more common as colonial rule progressed. Detribalization—something that encompassed such diverse aspects as “Christianization, secular education, working relationships with non-African employers, relationships with Government officials and with shop-keepers...life in townships, and the introduction of syphilis and alcoholic spirits and other drugs”—was particularly dangerous for Africans because of their reliance on traditional society to provide rules and protections.^{xxxi} The whole population, according to Carothers, was becoming highly unstable, as colonial rule increasingly disturbed “an equilibrium that had until recently been stabilised for so long.”^{xxxii}

These ideas eventually fed into accounts of the Mau Mau Emergency, an anti-colonial rebellion that gripped Kenya in the 1950s. At the request of the colonial government in Kenya, Carothers undertook a study of the psychological causes of the conflict and the implications for Kenya and the Kikuyu, the ethnic group at the heart of the rebellion.^{xxxiii} While Carothers acknowledged that political grievances were important, he attributed the root cause of the problem to “the African in transition.”^{xxxiv} Reiterating his arguments about the dangers of detribalization, Carothers emphasized that Mau Mau had been inevitable, arising “from the development of an anxious conflictual situation in people who, from contact with the alien culture, had lost the supportive and constraining influences of their own culture, yet had not lost their “magic” modes of thinking.”^{xxxv} The psychological instability of the African mind, still subject to tribal modes of thought, explained not only the rejection of

colonial rule, but the “obscene rituals” attributed to Mau Mau oaths, existing “in all the depravity that is imaginable.”^{xxxvi}

From the mid-1950s, the arguments of the East African School started to be disputed by those working in East Africa and further afield. Carothers was a focal point for this criticism due to his prominence as an “expert” in ethnopsychiatry following his World Health Organization-commissioned monograph *The African Mind in Health and Disease*.^{xxxvii} Writing in the *Journal of Mental Science*, T.A. Lambo insisted that studies of mental illness in Africa were:

At their worst...glorified pseudo scientific novels or anecdotes with a subtle racial bias; at their best...they are abridged encyclopedias of misleading information and ingenious systems of working hypotheses, useful for the guidance of research, but containing so many obvious gaps and inconsistencies, giving rise to so many unanswerable questions, that they can no longer be seriously presented as valid observations of scientific merit.^{xxxviii}

In Uganda, too, some of the more racist assumptions of the East African School started to be challenged by those attached to Makerere Medical School, Kampala, the only medical school in East Africa. In a clinical staff meeting in 1958, for example, Gerald I. Tewfik, Uganda’s Specialist Alienist and lecturer in psychiatry, noted that much of the psychiatric literature on Africa was often “inadequately supported” and “if true, would suggest that the African may have a failure of mental development which could be permanent.”^{xxxix} Likening the psychiatric literature to racial prejudice towards Jews in Europe, Tewfik added that “African behaviour can only be understood in the light of its culture; comparison with other nations cannot be relevant until a normal has been defined.”^{xl}

Calls for further research into what constituted “normal” African psychology proliferated with these assessments of the literature. Yet even if psychiatrists had started to question the more outrageous claims of the East African School—Carothers’ likening of African thinking to that of leucotomized Europeans being one—they could not escape the assumption that African societies were in a period of transition that might have major implications for mental health.^{xli} Indeed, the idea of the African in transition would continue to dominate the research agenda for the next twenty years, becoming all the more urgent in the context of decolonization. In East Africa, this research formed both the rationale for the training of Africans as psychiatrists and the intellectual climate in which the first generation started to work.

East African Psychiatrists

As preparations for decolonization started to accelerate, so the need for knowledge on what was “normal” and “abnormal” in the African was increasingly noted. “We need extensive research on African mental health not in the future but now,” claimed Donald Mackay, a mission doctor in Northern Rhodesia: “We need mental clinics in every township. We need men trained in psychiatry and steeped in African background to stem the tide of threatening maladjustment. We hear much of development—but where is there development so pressing as this.”^{xlii} Mackay urged European doctors already resident in Africa to pursue these topics; for him, Europeans were best placed to understand the need for such research. Other physicians, by contrast, felt that Africans would be better placed to understand what was “normal.” Responding to Mackay in an editorial in the *EAMJ* in 1948, John A. Carman, a medical officer based in Kenya, noted that because of the complex variations in African mentality, “the right type of African doctor is the only person who can hope to approach the subject in the proper way.”^{xliii} What constituted the “right type” of African doctor had long

been debated in East Africa, and particularly in Kenya, where Europeans feared that African medical assistants would “get too big for their boots.”^{xliv} While the situation was marginally better in Uganda, by 1949 African Medical Officers still had to contend with considerable restrictions in their pay and professional status, and were expected to remain subservient to European Medical Officers.^{xlv}

From the mid-1950s, these calls for further research were reinforced by the growth of transcultural psychiatry, which emerged as a discipline concerned with the presentation and management of mental illness across different cultures.^{xlvi} Transcultural psychiatry held particular appeal for psychiatrists in Africa because it allowed them to distance themselves from their discipline’s often overtly racist history—while ethnopsychiatry had been concerned with the psychology and behaviour of non-western peoples, transcultural psychiatry highlighted the ways in which “the vista of the scientific observer extends beyond the scope of one cultural unit on to others.”^{xlvii} Psychiatrists, it was noted, “must know about the cultural backgrounds of his patients and of the intricacies of detribalization in order to understand the motives, mental content and behaviour of his patients.”^{xlviii}

In the context of decolonization, this disciplinary shift allowed for renewed optimism about the future of psychiatric practice and research into the African in transition. Addressing the Uganda branch of the BMA in 1955, H.C. Trowell, Senior Specialist at Mulago Hospital, described some of the difficulties encountered when treating minor psychological disease. With his African patients, Trowell noted, he had only minimal understanding of “the medley of motives, hopes, fears, reserves and evasions.”^{xlix} These linguistic and cultural barriers made the training of African medical practitioners in psychiatric and psychological medicine both challenging and necessary—if western medicine was to be successful, doctors needed to be capable of understanding their patients. In Trowell’s opinion, Africans possessed natural cultural “insight” into their patients’ fears and anxieties that could be harnessed through

medical training, just as doctors in Europe might come to “detect” these signs in their own patients.

African doctors also claimed that they had special knowledge about their patients that could be advantageous in medical contexts. Opening an article on African patients in 1954, Eria M. Babumba noted that he “was brought up among his own people and knows what his fellow Africans are likely to think, their old beliefs and superstitions, and their usual fears.”ⁱ Graduates of Makerere Medical School similarly argued that African physicians, by right of birth, had “more direct communication with our fellow African than any other people....Patients trust us more.”^{li} Of course, what these discussions tended to overlook, usually for political reasons, was the vast cultural, social, and linguistic gap that existed between western-trained African medical practitioners and many of their patients. While between 1952 and 1962 the distribution of graduates from the medical school was fairly evenly divided between Uganda (66), Kenya (43), and Tanganyika (27), those graduating from Makerere were still drawn “more than proportionately from the more highly educated minority of the population.”^{lii} The gulf between African doctors and their patients, as we shall see later in this article, was not easily resolved by decolonization.

The idea that psychiatry might be best practised by Africans found fertile ground in Uganda, where the technical training of Africans had become one of the defining features of the Colonial Medical Service. Makerere Medical School, opened in 1923, was the second-longest running African medical school on the continent.^{liii} During the 1950s and 1960s, the school developed an internationally renowned reputation, placing it, if not quite “among the best medical schools in the world,” as William Derek Foster, Chair of Microbiology, has claimed, then at least among the best in Africa.^{liv} The annual intake of medical students grew substantially during the 1960s—from seventeen in 1962 to ninety in 1965—and it attracted over £280,000 in medical research grants between 1964-1967.^{lv} Concern over the effects of

detrribalization had not escaped the attention of staff at Makerere as they planned for the future. When the question of psychiatry was considered in 1959, they gave three main reasons for the urgency of its development as an academic subject: the difficulties experienced in recruiting a psychiatrist to replace Tewfik, who had resigned in 1958, leaving the school without a lecturer in psychiatry; evidence from the Student Health Service on the social and personal stresses facing students; and a conviction that “because of language difficulties and cultural attitudes psychiatry among Africans will best be practised by Africans.”^{lvi} The decision to establish a Department of Psychiatry, opened in 1966, would accelerate the development of mental health care in Uganda into one of the most innovative systems in Africa.

It is perhaps ironic that the body of research developed by the East African School, premised as it was on African inferiority, had come to provide one of the key arguments for the training of Africans as psychiatrists. The idea of the African in transition had not faded with the emergence of transcultural psychiatry. Rather, Africans were now credited with having natural cultural insight into these problems, which could be harnessed for clinical practice and research. Summing up the expectations for this new generation of psychiatrists, H.J. Simons, of the University of Cape Town, noted that in East Africa, African psychiatrists “would combine, as few other practitioners can do, the required knowledge of medicine and psychiatry with an intimate knowledge of the people’s physiognomy, language, and traits.”^{lvii}

It was in this context that Benjamin H. Kagwa, a Ugandan psychiatrist who had been living and working in the United States, accepted an invitation by the newly independent Ministry of Health to return to Uganda as a Consultant Psychiatrist. Kagwa was not the first Ugandan psychiatrist to practice in Uganda—that title goes to Stephen Bosa, who achieved the Conjoint Diploma in Psychological Medicine (DPM) at the Maudsley Hospital, London, in 1961—but he had been the first to qualify. The son of a former county chief, Kagwa had

left Uganda in 1928, travelling first to France and England, before continuing to the United States in pursuit of higher education.^{lviii} With financial support from his father and the native government of the Buganda Kingdom, Kagwa studied at Lincoln, Columbia, and New York University, where he gained the MD in 1940.^{lix} As he approached his graduation, however, the colonial government in Uganda informed him that they would not recognise his American qualifications. If he decided to return to Uganda, he would be registered as an African Assistant Medical Officer, the highest position an African medical practitioner could hope to achieve in Uganda at the time. Any higher position, it was noted, would undermine efforts to promote Uganda's own diploma in medicine.^{lx} The absurdity of the situation was highlighted by J.E.W. Flood, Director of Colonial Scholars, in 1939: "It is a perfectly lunatic situation that a black gentleman wearing a string of beads and a smile can practise "native medicine" if he likes, but poor Kagwa, who is a highly educated gentleman, would not be allowed to practise even with the M.D. of New York University unless he cares to set up as a "native" practitioner."^{lxi}

Feeling that he could not return to Uganda for this reason, Kagwa went on to complete a residency in neuropsychiatry at the Homer G. Phillips Hospital, St. Louis, a hospital staffed almost entirely by black doctors.^{lxii} Over the next twenty years, Kagwa worked at a range of hospitals in Chicago and New York, engaging fully with the intellectual communities he found there.^{lxiii} At a time when his colleagues in Uganda were still fighting for recognition of their qualifications and status, Kagwa was establishing a reputation for himself as a psychiatric expert.

Kagwa returned to Uganda in August 1963, feeling, according to his wife, Winifred Kagwa, a "moral responsibility" to "contribute to the development of his homeland."^{lxiv} He remained in Uganda for two years, working at Butabika Hospital, Uganda's only mental hospital, before returning to the United States. During this time, Kagwa travelled to eastern

Uganda to examine the outbreak of “mass madness” near Mbale. His investigation, which forms the basis for the rest of this article, represents the first scientific investigation by an indigenous-born psychiatrist in East Africa. In dealing with the question of mass mental instability and detribalization Kagwa engaged directly with issues that had preoccupied the East African School for the last thirty years. His research highlights both the difficulties facing East African psychiatrists as they took over responsibility for psychiatry, and the extent of the gulf between this new generation of psychiatrists and the patients they attempted to treat.

Epidemics of laughing, crying, and violence

In 1963, A.M. Rankin, Professor of Medicine, and P.J. Philip, Medical Officer, described how a “disease” of “laughing, crying and restlessness” had started the previous year at a mission-run girls’ school twenty-five miles from Bukoba, Tanganyika. In the subsequent months, the condition spread to other schools, affecting male and female pupils equally, but none of the European or African teachers.^{lxv} A typical patient, according to Rankin and Philip, had had contact with an affected person, and developed symptoms suddenly within a few days.^{lxvi}

In their discussion, Rankin and Philip pointed to some of the local explanations for the epidemic, which included a “belief that the atmosphere has been poisoned as a result of the atom bomb explosions.”^{lxvii} Many of their patients, they continued, “say that they are frightened of something, but do not give any further information. They appear to fear that someone is chasing them. There is a definite belief that this is a contagious condition of some kind. One villager described it as a spreading madness.”^{lxviii}

Rather than pursuing these explanations as signs of psychopathology, Rankin and Philip took blood and lumbar puncture samples, conducted physical examinations, and tested

local food substances, searching for an organic cause that they could identify and treat pharmaceutically.^{lxi} The invasiveness of their approach is striking, particularly in light of widespread anxiety over the use of needles in public health campaigns. Lumbar punctures were not only extremely painful, but required the patient to be forcibly held down, an experience that could in itself evoke horror and psychic disturbance.^{lxx} If Rankin and Philip's patients were indeed "frightened of something," then their encounters with western medical technologies would hardly have eased any anxiety. Nevertheless, when the tests came back negative, Rankin and Philip concluded that mass hysteria was the only remaining explanation.

A few months later, the District Medical Officer (DMO), Kigezi, in south-west Uganda, reported that there had been an "out break [sic.] of lunacy" in the District. Kigezi High School was closed, and large sections of the rural population affected.^{lxxi} The DMO took steps to request assistance from Mulago Hospital, Kampala, as well as the services of a government psychiatrist. Yet while blood tests were carried out among those affected, and "tablets" distributed "in order to mitigate the effects of the attack," no specialist help was forthcoming.^{lxxii} Ten months later, the Kigezi District Team complained that despite the fact that the epidemic was still ongoing, "no Government psychiatrist had come for investigation," and urged the DMO to take the matter more seriously.^{lxxiii} The historical record leaves no further traces of the epidemic. Neither does it provide any indication of why no specialist help was available during an epidemic that was reported to have affected well over 600 people.^{lxxiv} When similar reports were received from medical officers in Mbale, over 400 miles away, the response from the Ugandan Government was quite different. As the Kigezi District Team continued to struggle with their epidemic, Kagwa was released from his duties at Butabika Hospital to travel to eastern Uganda, and to initiate a scientific investigation.

Kagwa's paper on the epidemic at Mbale in 1963-1964 came to the same conclusion as that of Rankin and Philip. Rather than reaching his diagnosis by process of elimination, however, Kagwa felt that he was able to prove, "without doubt," the diagnosis of hysteria. In describing the epidemic of "running mania," Kagwa divided the madness into three stages. The first came on suddenly and lasted three to four days. It was characterized by "marked agitation, talkativeness, violence, attempted assaults and petty robbery, with anorexia and a craving to smoke." The second was marked by sporadic relapses of hyperactivity, lasting one to two weeks. And the third was characterized by "improvement in mood, affability and a willingness to be interviewed."^{lxxv} According to his research, all of the original cases were Bagisu men and women, either illiterate or near-illiterate, and in no position of authority.^{lxxvi}

In discussing possible causes for the outbreak, Kagwa noted that those affected believed very strongly that the madness was caused by ancestral spirits. "All this was said to be done," Kagwa asserted, "in response to the orders of the spirits of dead family elders. This phase had a quality of a quasi-manic reaction with obvious transparent delusions and hallucinations. Those affected stated that they could see the faces and hear the voices of their dead elders."^{lxxvii} Surprisingly, Kagwa did not pursue this line of inquiry, despite expressing sympathy for prominent psychoanalysts such as Freud, who argued that an individual or group's ideas, fears, and anxieties could produce hysteria.^{lxxviii} Like Rankin and Philip, he instead initiated a series of invasive physical and neuropsychiatric tests that included lumbar punctures, hypnosis, drug abreaction, and the pushing of pins an inch deep into the flesh in order to show total anaesthesia.^{lxxix} Ignoring the possibility that his actions had caused distress, Kagwa asserted that his tests and interviews showed "several objective classical hysterical findings." These included "sudden onset of the attacks, sudden clearance of symptoms," and total numbness. For Kagwa, "all clinical studies proved, without doubt, the diagnosis of conversion hysteria."^{lxxx}

In making this statement, Kagwa was using his examination of individuals to diagnose the collective. This, he justified by noting that “one striking feature” of the three epidemics was “the stereotypy of symptoms in each particular ethnological group. The “attacks” and spread of similar symptoms ran along tribal lines. Even in instances where it spread over geographical borders the epidemics affected only members of the same tribe and culture.”^{lxxxix} The statements mirrored those made by Rankin and Philip, who had stressed that mental illness was “influenced by the culture of the particular community.”^{lxxxii} Yet while Rankin and Philip were reluctant to draw further conclusions before a study of the cultural context in Bukoba had been undertaken, Kagwa was more confident of his understanding of mental illness across East Africa. As a psychiatrist—and an African one at that—he not only confirmed that these were a series of epidemics, but that they had implications for political, social, and economic stability in the region—epidemics of mass hysteria were a new East African “problem.” In his analysis, however, Kagwa would fall back on many of the assumptions of the East African School, and would conflate ethnicity and culture with race.

Kagwa drew heavily on Carothers’ notion that the introduction of western culture into Africa was upsetting an “equilibrium,” and that Africans were ill-equipped, both culturally and environmentally, to cope with these changes.^{lxxxiii} Echoing Carothers, Kagwa noted that:

Consciously or unconsciously, at this period of their development, the majority of Africans have conflicts of great psychological dimensions, though they may differ in character. For example, among the educated the conflict may be verbalized in terms of political, economic or educational unrest and action, while among the illiterate and near-illiterate confusion of ideas and emotions, as well as substitution of mysticism for logic, is the rule....the latter group, which is of course in the majority, has been thrust into sudden religious and political changes without preparation.^{lxxxiv}

Kagwa's use of Carothers is not entirely surprising given the continued interest of psychiatrists and psychologists in the idea of the African in transition. While statements about the dangers of "development," as with a number of contentions of the East African School, were increasingly controversial, these authors had nevertheless produced the only substantial body of literature on African psychopathology. Moreover, the World Health Organization, which had commissioned Carothers' *The African Mind*, stood publicly by the text as late as 1962 as a "good example" of an investigation "of the peculiar qualities of mental organization in individual cultural groups."^{lxxxv}

Despite his reliance on ideas about "psychic trauma," "culture contact," and "detrribalization," Kagwa certainly believed that his investigation was less racially motivated than that which had come before under colonial rule. Significantly, Kagwa was keen to stress that his analysis did not mean that mass hysteria was a cultural or racial peculiarity affecting Africans alone. Discussing the historical background of mass hysteria, Kagwa noted that "[h]ysteria, as a human behavioural phenomenon, can be traced as far back as the beginning of man's rational psycho-social development"; it was functional, providing an "outlet for dammed-up instinctive demands."^{lxxxvi} In so doing, Kagwa stressed the universal applicability of western psychiatry alongside the existence of a linear scale of development on which African 'civilization' was passing through one stage. There was "much historical evidence," Kagwa added, "to prove that emotional upheavals associated with hysteria occur whenever a people's cultural roots and beliefs become suddenly shattered."^{lxxxvii} These precedents included demon possession in the Bible, the hysterical deliria of saints, and epidemics of dancing mania in Metz, Cologne, and Aix-la-Chapelle in the fourteenth and fifteenth centuries.^{lxxxviii}

By including these examples Kagwa was following a trend in western medicine of analysing historical accounts of disease, as if it might aid understanding of why and when epidemics of hysteria occur.^{lxxxix} In ways reminiscent of older theories of recapitulation, this body of literature linked the “primitive” mentalities of peasants from medieval Europe with twentieth-century schoolchildren, members of religious cults, and black Americans, among others.^{xc} The problem with this approach was the way it assumed that mass hysteria had always existed in a universal and recognisable form, and that retrospective diagnoses could shed light on present understandings.^{xcii} Indeed, for Kagwa, as it had been for Rankin and Philip, mass hysteria was an objective reality; it could spread from person to person just as other types of epidemic disease were “caused by the spread of viruses, bacteria or parasites.”^{xcii}

Despite Kagwa’s attempts to distance himself from overtly racist statements, he could not escape the assumption that African societies were undergoing a period of psychological transition. He saw no contradiction between his finding that the epidemics ran along ethnic lines and his belief in the existence of a homogenous African culture that was, at this particular time, susceptible to mass instability. This “African culture” was the only useful unit of analysis, just as it had been for Carothers—there was little room for socio-economic change, cultural diversity, or individuality. As we shall see in the final section, it was Kagwa’s attempt to understand the epidemics through this particular theoretical lens that accounts for the conceptual gap between him and his Gisu patients.

Multiple responses to “mass madness”

Kagwa could have found plenty of socio-economic tensions in the Mbale region, had he looked for them. Administrative structures at the local level were being dismantled as President Milton Obote and the Uganda People’s Congress (UPC) attempted to assert their

control over the districts.^{xciii} Moreover, in an already densely populated area, there was increasing pressure on land and fluctuating coffee prices, contributing to a perception that theft, bhang growing, drinking, witchcraft, and violence were getting out of control.^{xciv} Such was the extent of fear over these issues that from the mid-1960s two types of neighbourhood organizations—vigilante groups and drinking companies—were formed across the area in order to curb social activities that were deemed to be dangerous.^{xcv} The local administration, too, started to meet regularly to question how they could respond to the rising homicide rate and general unrest in the area. In the few years since Independence, as the Intelligence Committee noted in 1964, “the traditional customs and superstitions which tamed the man to abide by certain rules of laws have disappeared. Religio[n]s which have been brought in by foreign powers are heavily under criticism and losing ground. Many fathers have lost the old control that they used to have over their children. Drunkenness has increased with little criticism from parents.”^{xcvi}

If these tensions prompted mass action or healing in the form of a protest cult, it was not recognized as such by anthropologists, psychiatrists, or those affected. Nevertheless, Gisu elders living in the area surrounding Mbale recalled that there was a time when madness was common, when “so many people were attacked around the villages.”^{xcvii} They remembered how some people became aggressive, felt hot, and cried uncontrollably, while others suffered from headache, itchiness, and ran wild. “At times I would feel like I was losing my senses,” one informant recalled, “and some times could not trace my home.”^{xcviii} “He was very much aggressive and sometimes silent,” as another informant spoke of a man in a neighbouring village. Such was his confusion in his final days, she added, that he wandered into the path of a vehicle and was killed.^{xcix}

Although there was some uncertainty about the exact period, the madness (*tsitsoli*) was said to have come suddenly during the years immediately preceding and following

Independence, lasted a few months, and never recurred. It was if mass madness, as a number of elders described it, was a “disease of that time” (*lufu lwembuka yo*), just as HIV/AIDS is regarded as a “disease of today.”^c This way of remembering the epidemic both indicated the extent to which it had affected families and communities, and pointed to the ways Gisu elders periodized time by major events and disturbances. Gisu circumcision names (*kamengilo*), for example, as Pamela Khanakwa has explained, were usually associated with significant social, economic, and political events.^{ci} The 1966 circumcision name, for example, was *muwambe*, meaning “capture, catch or hold him,” and referred directly to a spate of forced circumcisions that had occurred across the area.^{cii}

The madness was said to have come and spread with the wind (*imbewo*).^{ciii} According to Gisu elders, while it was more common among the youth, it did not discriminate by gender, education, or age.^{civ} This, they added, was due to the will of *were*, the creator spirit.^{cv} In explaining the madness, a number of explanations were put forward, including a curse from the ancestors and witchcraft (*liloko* and *bulosi*).^{cvi} One informant stressed her uncertainty over the cause of the madness, instead adding that other people had a theory that it was due to “sophisticated bombs.”^{cvi} Another was certain that it had come from “outside,” being perhaps an unknown force from Europe.^{cvi} No contradiction was seen in the diversity of explanations—ideas about agency behind the madness reflected the more general belief that while the creator spirit was in charge of fate, agency could be ascribed to sorcery, the anger of the ancestors, or other spirits.^{cix} It is interesting, however, considering Kagwa’s description of one of the main symptoms as a “running mania,” that one of the words for witchcraft or a supernatural attack, *bulosi*, is also used by the Gisu to denote violence and aggression.^{cx}

Looking at the *amandiki* women of early twentieth-century Zululand, Julie Parle has highlighted the ways in which ideas about spirit possession and mental illness reflect “a

variety of opinions, the diversity of which is testimony to its complicated and shifting nature, and the ‘accuracy’ of which may reflect only one of a variety of meanings across both time and space.”^{cxii} This insight is reinforced by the competing explanations of mass hysteria in 1960s Uganda—the extent to which Gisu elders recalled uncertainty and suspicion, both towards the behaviors they witnessed and the people who came to investigate, remind us that historians should not focus solely on diagnosis. One man, for example, recalled two Europeans coming to conduct an investigation into the local water supply at the same time as people in his and nearby villages were running mad. These Europeans, he believed, were only interested in the water because the madness had “started from abroad....In countries like Germany.”^{cxiii} This explanation might be best attributed to anxieties about the nature of medical research and colonial rule.^{cxiii} But it might also be taken as an indication of the cultural and political gulf between the Gisu, the local authorities, and western medical practitioners. What for the two Europeans was a routine and unobtrusive water test, became for this man something altogether more disturbing. Indeed, because the Europeans “knew about the disease,” they could avoid being infected, having “covered themselves with protective masks.”^{cxiv}

These different ways of “seeing” and understanding were not resolved with the coming of independence or with the emergence of African psychiatrists. Kagwa may have been an African by birth, but he was from central rather than eastern Uganda, and his years in the United States had further distanced him from the people he was trying to help. As Kagwa noted later, he had returned to Uganda with a set of assumptions about the African mind that were rooted in western psychiatric theory, rather than any special insight derived from being a Ugandan psychiatrist.^{cxv} His analysis of the epidemic as a wider cultural and developmental issue stands starkly against the social, political, and economic tensions that existed in the

area, as well as the explanations of the Gisu. In spite of this, or perhaps because of it, there remained a large question mark over how the “problem” of mass hysteria should be handled.

If Kagwa believed in the universal applicability of psychiatry for understanding mental illness, he was nevertheless aware of the limits of his power in Uganda. A Psychiatric Unit to serve the whole Eastern Region had opened at Mbale Hospital in 1963-1964, staffed by a small group of psychiatric nurses, but only four beds were available during the period under question.^{cxvi} Kagwa, moreover, was only able to apply his neuropsychiatric “test” to those in the recovery stage of the epidemic, and does not appear to have been allowed to offer his own treatments. Just because Kagwa was a Ugandan psychiatrist, it did not mean that families and communities were any more likely to turn to him for help.

Such were the limits of Kagwa’s role in the Mbale region that he was left to describe how it was Gisu elders “who perform the healing ritual.” These elders, Kagwa continued:

start at sunrise by visiting the burial grounds of the clan and by weeding the tombs, near which they build small huts. White chickens are slaughtered and their blood used to anoint the tombs. Pieces of chicken, baked plantains and calabashes of wine are then placed in the huts. These are gifts to the spirits of dead clan elders. Finally, one elder sips the wine and spits it on the feet of the “possessed”, who then becomes instantaneously and dramatically healed. Interestingly enough, the word for this ritual is equivalent to the English word “exorcism”.^{cxvii}

Kagwa’s account fit with that described by anthropologist Jean La Fontaine on the sacrificing of white animals to “good” spirits and to the ancestors.^{cxviii} By focusing on the dramatic, however, such accounts ignored the importance of other healing methods, including herbs, protective charms, and western medicine.

Like other ethnic groups in Uganda, the Gisu distinguished between the symptomatic and etiological treatment of illness, focusing first on relieving symptoms before looking for a deeper cause.^{cxix} Numerous informants referred to the widespread availability of herbal medicine, something that was regarded as the first line of treatment in cases of sickness.^{cxx} One man, for example, described how he had become mad for a short period around the time of independence, at the same time as many others. He was unable to recall much about his experience, but stressed how disoriented he felt, and how it caused him difficulties in finding his way home. His mother was in charge of making decisions about his treatment and, with the approval of his close family, chose to visit a healer who specialised in herbs. While herbalists were usually relied upon largely because of their proximity, in this case an additional reason was given: through herbal medicine “they had seen other victims heal.”^{xxxi}

In addition to herbs, families could turn to other forms of traditional medicine, which included protective charms (*tsisale*) being placed under the skin, and ritual specialists who had the ability to remove bad omens and curses.^{xxxi} The methods and meetings of these specialists were usually highly secretive, but could include sacrifices to appease the spirits or to drive out misfortunes.^{xxxi} Western medicine was also an option for those seeking relief and, despite the long distances that needed to be travelled, a number of people were taken to hospitals or clinics at Mbale and Bududu.^{xxxi} One woman recalled how family members would only initiate treatment when people became aggressive, and then a person would either be tied up, taken to hospital, a traditional healer, or left to die. One of her neighbours, she added, was first taken to the government hospital at Mbale, in part because it was not far from their home, but also because that was what their local chief encouraged them to do. This particular person recovered in the hospital, and as a result, others from her village were also taken for treatment there.^{xxxi}

Distance was a key factor in the decision-making process for families affected by the epidemic. More often than not, distances were perceived to be too great,^{cxxvi} particularly for those who were not convinced of the ability of western medicine to deal with illnesses associated with ancestral spirits.^{cxxvii} Moreover, a few also regarded hospitals as places of danger, in the way Luise White has highlighted more generally for East and Central Africa.^{cxxviii} “Some people had a false belief,” one informant recalled, “that in hospitals medicines were made out of dead people.”^{cxxix} Such a comment reveals concern over the power of European therapies, and the control that was felt over bodies and minds.

As elsewhere in Africa, it was families and the larger kinship group who played a central role in making decisions about care and treatment, displaying a pragmatism that allowed for alternative treatment options to be explored.^{cxxx} Indeed, as John Orley noted on his experience of illness and disease in central Uganda, “Africans, being pragmatists, looked for a system that worked, and if one traditional remedy failed then another could be tried and so on until eventually Western medical treatment could also be given its chance.”^{cxxxi} Among the Gisu, such was the extent of this pragmatism that different methods of treatment were even used simultaneously. One woman, for example, described how her brother was among those who went mad, becoming extremely aggressive and feeling cold to the touch. As a family they had first taken him to Mbale Hospital, but then decided that in addition to western medicine, they would also consult two different traditional healers. When questioned as to why they tried three kinds of treatment at a go, she laughed, before responding: “[w]e wanted him to get cured.”^{cxxxii} This was not a question of selecting traditional or western medicine, but rather a process of searching for relief.

The epidemics of the early 1960s indicate some of the limits, rather than the strengths, of psychiatry in early postcolonial Uganda. They remind us that psychiatry was not necessarily transformed with the emergence of African psychiatrists, even if contemporaries

had credited them with having natural cultural “insight” into “the African mind.” In Mbale, Kagwa was unaware of the widespread uncertainty and suspicion about the epidemic, both in terms of the behaviors communities had to deal with, and the strangers who came to investigate. When the Gisu looked for options for relief, they turned to their own methods of healing—methods that did not include psychiatry. Kagwa, himself an outsider, was unable to intervene, his role reduced from psychiatric expert to that of observer.

Conclusion

During the colonial period in East Africa, the long-held assumption that Africans were prone to periodic outbursts of insanity was underpinned by the research of psychiatrists and psychologists, who argued that contact with western civilization was inherently dangerous for “primitive minds.” Calls for further research into this problem—encapsulated in the idea of the “African in transition”—intensified as the colonies moved towards decolonization, and set up the conditions that allowed for the emergence of African psychiatrists in East Africa. It was in this intellectual climate that Kagwa was invited back to Uganda to serve under the newly independent Ministry of Health. His investigation into the epidemic of mass hysteria in eastern Uganda represented the first formal attempt by an African psychiatrist in East Africa to engage with the theories and personalities of the East African School. Yet while Kagwa certainly believed that his approach was less racist than much of the literature that had come before him, he was not able to free himself fully from the assumptions that had pervaded his discipline under colonial rule. Significantly, Kagwa continued to see explanations given by his Gisu patients as signs of pathology. Moreover, like psychiatrists and psychologists before him, Kagwa also believed it was possible to generalize about mental illness in African communities and to identify broad cultural traits and “experiences.”

While Kagwa's reliance on psychiatrists like Carothers placed him firmly within a much longer tradition of psychiatry in East Africa, it would be unfair to present Kagwa as an anomaly among the new generation of African psychiatrists emerging elsewhere in Africa. Indeed, even the most critical of the African psychiatrists, T.A. Lambo, found it difficult to navigate a path through the existing body of literature on the African mind. As Heaton has noted, "[d]espite arguing for a deracialization of psychiatric theory and practice, Lambo himself often employed racialized categories and terminologies very reminiscent of colonial psychiatrists like Carothers."^{xxxiii}

Over the next decade, the epidemics of mass hysteria became a focus for transcultural psychiatrists working both within and outside of Africa. Moving beyond Kagwa's interest in the peculiarities of the African psyche, these discussions not only questioned why such epidemics occurred, but what they revealed about treatment choices in different cultural settings. At a Ciba Foundation Symposium on Transcultural Psychiatry, held in London in 1965, the events in East Africa were compared with epidemics of mass hysteria among islanders from Tristan da Cunha, *ufufenyane* among Zulu-speaking peoples in South Africa, and Beatlemania. Lambo, who claimed to have worked with Kagwa on his investigation, stressed that the finding that most people took their relatives to traditional healers was significant. Highlighting the "differences between an African physician...with a completely western medical education and the local therapists," Lambo observed how "[a] rural African coming from his village to consult me may say to himself: 'Well, this man won't really have any sympathy with me, I will not come next time. I'm wasting my time with him'."^{xxxiv}

By the mid-1960s, the initial optimism that had accompanied calls for the training of Africans as psychiatrists had faded away. The question of how psychiatrists in Africa—both African and expatriate—could bridge the gap between western psychiatry and African patients would come to dominate the agendas of pan-African conferences and workshops

over the next twenty years. This would in turn raise further questions about the training of general medical practitioners in mental health care, the place of traditional healers in psychiatry, and mental health public education programs.^{cxxxv} The problem of the distance between psychiatrists and patients, of course, was not limited to the African context. In the United Kingdom, where psychiatrists were drawn almost exclusively from the upper echelons of society, the 1960s saw a proliferation of studies highlighting the difficulties of communication across class, education, and linguistic divides.^{cxxxvi} Given the formative nature of the discipline of psychiatry in Africa, however, the problems experienced by psychiatrists such as Kagwa took on particular significance during the 1960s and 1970s. It was through discussions among those working in the continent, as much as in new research conducted by psychiatrists, that the nature of “African” psychiatry was debated and refined.

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- i. Robert Conley, "Laughing Malady Puzzle in Africa," *New York Times*, 8 August 1963, 29.
 - ii. A.M. Rankin and P.J. Philip, "An Epidemic of Laughing in the Bukoba District of Tanganyika," *Cent. Afr. J. Med.*, 1963, 9, 167-170.
 - iii. Benjamin H. Kagwa, *A Ugandan: Defiant and Triumphant* (Hicksville: Exposition Press, 1978); Benjamin H. Kagwa, "The Problem of Mass Hysteria in East Africa," *East Afr. Med. J.*, 1964, 41, 560-566.
 - iv. Interview with Gisu female, 61 years old, Mbale District, 27 October 2011 (MLE-07); Interview with Gisu female, 78 years old, Mbale District, 1 November 2011 (MLE-16); Interview with Gisu male, 74 years old, Mbale District, 27 October 2011 (MLE-06).
 - v. Minutes of the Kigezi District Team, August 1963 – July 1964, Kabale District Archives; "Mystery of the Laughing and Crying Disease," *Uganda Argus*, 15 August 1963, 3; Conley, "Laughing Malady"; G.J. Ebrahim, "Mass Hysteria in School Children: Notes on Three Outbreaks in East Africa," *Afya*, 1969, 3, 7-9; Kagwa, "The Problem of Mass Hysteria"; Rankin and Philip, "An Epidemic."
 - vi. On medical education in East Africa, see John Iliffe, *East African Doctors: A History of the Modern Profession* (Kampala: Fountain Publishers, 2002); Maryinez Lyons, "The Power to Heal: African Medical Auxiliaries in Colonial Belgian Congo and Uganda," in *Contesting Colonial Hegemony: State and Society in Africa and India*, ed. Dagmar Engels and Shula Marks (London: British Academic Press, 1994); A.M. Odonga, *The*

First Fifty Years of Makerere Medical School and the Foundation of Scientific Medical Education in East Africa (Kampala: Marianum Press, 1989); W.D. Foster, "Makerere Medical School: 50th Anniversary," *BMJ*, 14 September 1974, 675-678.

- vii. This literature includes: Megan Vaughan, "Idioms of Madness: Zomba Lunatic Asylum, Nyasaland, in the Colonial Period," *J. South Afr. Stud.*, 1983, 9, 218-238; Richard C. Keller, *Colonial Madness: Psychiatry in French North Africa* (Chicago: University of Chicago Press, 2007); Jock McCulloch, *Colonial Psychiatry and 'the African Mind'* (Cambridge: Cambridge University Press, 1995); Lynette A. Jackson, *Surfacing Up: Psychiatry and Social Order in Colonial Zimbabwe, 1908-1968* (Ithaca: Cornell University Press, 2005); Julie Parle, *States of Mind: Searching for Mental Health in Natal and Zululand, 1868-1918* (Scottsville: University of KwaZulu-Natal Press, 2007); Harriet Jane Deacon, "Madness, Race and Moral Treatment: Robben Island Lunatic Asylum, Cape Colony, 1846-1890," *Hist. Psychiatr.*, 1996, 7, 287-297; Leland Bell, *Mental and Social Disorder in Sub-Saharan Africa: The Case of Sierra Leone, 1787-1990* (New York: Greenwood Press, 1991); Sloan Mahone and Megan Vaughan, *Psychiatry and Empire* (Basingstoke: Palgrave Macmillan, 2007).
- viii. Julie Parle provides a notable exception here: Parle, *States of Mind*.
- ix. On this "school," see especially Gail C. Beuschel, "Shutting Africans Away: Lunacy, Race and Social Order in Colonial Kenya, 1910-1963" (PhD diss., SOAS, 2001), chap. 7; Sloan Mahone, "East African Psychiatry and the Practical Problems of Empire," in *Psychiatry and Empire*, ed. Sloan Mahone and Megan Vaughan (Basingstoke: Palgrave Macmillan, 2007); Sloan Mahone, "Psychiatry in the East African Colonies: A Background to Confinement," *Int. Rev. Psychiatr.*, 2006, 18, 327-332; Megan Vaughan, *Curing Their Ills: Colonial Power and African Illness* (Cambridge: Polity Press, 1991), 110-112.
- x. Chloe Campbell, *Race and Empire: Eugenics in Colonial Kenya* (Manchester: Manchester University Press, 2007), chap. 3; Anna Crozier, *Practising Colonial Medicine: The Colonial Medical Service in British East Africa* (New York: I.B. Tauris, 2007), 96-7; Sloan Mahone, "The Psychology of the Tropics: Conceptions of Tropical Danger and Lunacy in British East Africa" (DPhil diss., University of Oxford, 2004), 111.
- xi. J.C. Carothers, "A Study of Mental Derangement in Africans, and an Attempt to Explain Its Peculiarities, More Especially in Relation to the African Attitude to Life," *East Afr. Med. J.*, 1948, 25, 197-219. On Carothers' study, see Vaughan, *Curing Their Ills*, chap. 5.
- xii. For a review of recent literature, see Roberta Bivins, "Coming 'Home' to (Post)Colonial Medicine: Treating Tropical Bodies in Post-War Britain," *Soc. Hist. Med.*, 2012, 26, 1-20.
- xiii. Alice Bullard, "Imperial Networks and Postcolonial Independence: The Transition from Colonial to Transcultural Psychiatry," in *Psychiatry and Empire*, ed. Sloan Mahone and Megan Vaughan (Basingstoke: Palgrave Macmillan, 2007); Matthew Heaton, "Stark Roving Mad: The Repatriation of Nigerian Mental Patients and the Global Construction

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- of Mental Illness, 1906-1960" (PhD diss., University of Texas at Austin, 2008); Keller, *Colonial Madness*, chap. 6.
- xiv. Heaton, "Stark Roving Mad," 106.
 - xv. Examples include: Kathleen Vongsathorn, "'First and Foremost the Evangelist'?" Mission and Government Priorities for the Treatment of Leprosy in Uganda, 1927-48," *J. East Afr. Stud.*, 2012, 6, 544-560; Grace Carswell, *Cultivating Success in Uganda: Kigezi Farmers and Colonial Policies* (Oxford: James Currey, 2007); Edgar C. Taylor, "Claiming Kabale: Racial Thought and Urban Governance in Uganda," *J. East Afr. Stud.*, 2013, 7, 143-163.
 - xvi. For further information on working in Uganda's archives, see Stuart McConnell, "Historical Research in Eastern Uganda: Local Archives," *Hist. Afr.*, 2005, 32, 467-478; Michael William Tuck and John Allen Rowe, "Phoenix from the Ashes: Rediscovery of the Lost Lukiiko Archives," *Hist. Afr.*, 2005, 32, 403-414; Kathryn Barrett-Gaines and Lynn Khadiagala, "Finding What You Need in Uganda's Archives," *Hist. Afr.*, 2000, 27, 455-470.
 - xvii. The most accessible collections are located at Kabale, Jinja, Fort Portal, and Soroti.
 - xviii. Respondents were not paid for interviews, but were given small gifts of sugar at the end of the interviewing process. All interviews were conducted in Lugisu and recorded with a digital voice recorder. Due to the sensitive nature of the subject matter, respondents are not named in this article.
 - xix. Marjorie Shostak, "'What the Wind Won't Take Away': The Genesis of *Nisa - the Life and Words of A !Kung Woman*," in *The Oral History Reader*, ed. Robert Perks and Alistair Thomson (London: Routledge, 1998), 404.
 - xx. Gerhard Lindblom, *The Akamba in British East Africa: An Ethnological Monograph* (Uppsala: Archive d'Etudes Orientales, 1920), 239.
 - xxi. Ibid. See also Grace Harris, "Possession Hysteria in a Kenya Tribe," *Am. Anthropol.*, 1957, 59, 1046-1066. For a fuller treatment of *kijesu*, see Sloan Mahone, "The Psychology of Rebellion: Colonial Medical Responses to Dissent in British East Africa," *J. Afr. Hist.*, 2006, 47, 241-258.
 - xxii. *Nyabingi* has been refigured more recently as a set of logics and practices associated with attempts to gain redress for misfortune. See especially Richard Vokes, *Ghosts of Kanungu: Fertility, Secrecy & Exchange in the Great Lakes of East Africa* (Kampala: Fountain Publishers, 2009), chap. 2; Steven Feierman, "Colonizers, Scholars, and the Creation of Invisible Histories," in *Beyond the Cultural Turn: New Directions in the Study of Society and Culture*, ed. Victoria E. Bonnell and Lynn Hunt (Berkeley: University of California Press, 1999).
 - xxiii. Holger Bernt Hansen, "The Colonial Control of Spirit Cults in Uganda," in *Revealing Prophets: Prophecy in Eastern African History*, ed. David M. Anderson and Douglas H. Johnson (London: James Currey, 1995), 154.

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- xxiv. See, for example, Margaret Wrong, "Mass Education in Africa," *Afr. Aff.*, 1944, 43, 105-111, 109.
- xxv. Mahone, "Psychology of Rebellion."
- xxvi. See, for example, H. Shelley and W.H. Watson, "An Investigation Concerning Mental Disorder in the Nyasaland Natives," *J. Ment. Sci.*, 1936, 82, 701-730.
- xxvii. H.L. Gordon, "The Mental Capacity of the African: A Paper Read before the African Circle," *J. R. Afr. Soc.*, 1934, 33, 226-242; James H. Sequeria, "The Brain of the East African," *BMJ*, 26 March 1932, 51-106. On eugenics in Kenya see Campbell, *Race and Empire*.
- xxviii. H.L. Gordon, "An Enquiry into the Correlation of Civilization and Mental Disorder in the Kenyan Native," *East Afr. Med. J.*, 1936, 12, 327-335, 333.
- xxix. *Ibid.*, 329.
- xxx. JLH, "J C D Carothers," *BMJ*, 14 April 1990, 1010.
- xxxi. Carothers, "Study of Mental Derangement," 153-4.
- xxxii. *Ibid.*, 217-8.
- xxxiii. J.C. Carothers, *The Psychology of Mau Mau* (Nairobi: Government Printer, 1955), 1. On the Mau Mau Emergency see David M Anderson, *Histories of the Hanged: The Dirty War in Kenya and the End of Empire* (London: W.W. Norton, 2005); Caroline Elkins, *Britain's Gulag: The Brutal End of Empire in Kenya* (London: Jonathan Cape, 2005); Daniel Branch, *Defeating Mau Mau, Creating Kenya: Counterinsurgency, Civil War and Decolonisation* (Cambridge: Cambridge University Press, 2009).
- xxxiv. Carothers, *Psychology of Mau Mau*, 12.
- xxxv. *Ibid.*, 15.
- xxxvi. *Ibid.*
- xxxvii. J.C. Carothers, *The African Mind in Health and Disease: A Study in Ethnopsychiatry* (Geneva: WHO, 1953).
- xxxviii. T.A. Lambo, "The Role of Cultural Factors in Paranoid Psychosis among the Yoruba Tribe," *J. Ment. Sci.*, 1955, 101, 239-266, 241.
- xxxix. G.I. Tewfik, "Mulago Hospital Clinical Staff Meeting April 26, 1958: The African Mind Fact or Myth?," *East Afr. Med. J.*, 1958, 35, 512-513, 512.
- xl. *Ibid.*

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- xli. J.C. Carothers, "Frontal Lobe Function and the African," *J. Ment. Sci.*, 1951, 97, 122-148, 122.
 - xl.ii. Donald Mackay, "A Background for African Psychiatry," *East Afr. Med. J.*, 1948, 25, 2-4, 4.
 - xl.iii. "Editorial," *East Afr. Med. J.*, 1948, 25, 1.
 - xl.iv. H.C. Trowell, as cited in Iliffe, *East African Doctors*, 45-6.
 - xl.v. On the struggles of African doctors to achieve professional status, see Iliffe, *East African Doctors*, chap. 5.
 - xl.vi. E.D. Wittkower, "Transcultural Psychiatry," in *Modern Perspectives in World Psychiatry*, ed. John G. Howells (Edinburgh: Oliver & Boyd, 1968); Jatinder Bains, "Race, Culture and Psychiatry: A History of Transcultural Psychiatry," *Hist. Psychiatr.*, 2005, 16, 139-154, 139; Raymond Prince, "Origins and Early Mission of Transcultural Psychiatry: Some Personal Recollections," *World Cult. Psychiatr. Res. Rev.*, 2006, 1, 6-11.
 - xl.vii. Wittkower, "Transcultural Psychiatry," 697. On ethnopsychiatry, see Jock McCulloch, "The Empire's New Clothes: Ethnopsychiatry in Colonial Africa," *Hist. Hum. Sci.*, 1993, 6, 35-52.
 - xl.viii. Edward L. Margetts, "The Future for Psychiatry in East Africa," *East Afr. Med. J.*, 1960, 37, 448-456, 453.
 - xl.ix. H.C. Trowell, "Training Medical Practitioners," *East Afr. Med. J.*, 1956, 33, 253-258, 257.
 - l. Eria M. Babumba, "An African Patient," *East Afr. Med. J.*, 1954, 31, 373-376, 373.
 - li. A discussion between the Hon'ble the Director of Medical Services and the Makerere Medical Graduates Associations' Delegation, 1950, in Makerere Medical Graduates Association (1950-1992), 9, PH/ASC/46 (Box 29), Uganda Ministry of Health Archives.
 - lii. J.E. Goldthorpe, *An African Elite: Makerere College Students 1922-1960* (Nairobi: Oxford University Press, 1965), 46; F.G. Sembeguya, "The Growth of an Indigenous Medical Profession," *East Afr. Med. J.*, 1964, 41, 39-45, 40.
 - lii.iii. Medical schools were opened in Senegal in 1918, Uganda in 1923, Sudan in 1924, Cameroon in 1928, and Nigeria in 1930. Medical schools in South Africa did not accept black Africans until the 1940s. Anne Digby, "Early Black Doctors in South Africa," *J. Afr. Hist.*, 2005, 46, 427-454; Iliffe, *East African Doctors*, 60-2; Adell Patton, *Physicians, Colonial Racism, and Diaspora in West Africa* (Gainesville: University Press of Florida, 1996), 24.
 - liv. Foster, "Makerere."

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- iv. Carol Sicherman, *Becoming an African University: Makerere, 1922-2000* (Trenton: Africa World Press, 2005), 153.
- lvi. Application to the Nuffield Foundation for the Services of a Visiting Consultant to Advise the College on Provision for Teaching and Research in Psychiatry and the Training of African Psychiatrists, April 1959, 1-2, in Makerere University, Mulago Medical School and Hospital, BW 90/190, The National Archives, United Kingdom [hereafter TNA].
- lvii. H.J. Simons, "Mental Disease in Africans: Racial Determinism," *J. Ment. Sci.*, 1958, 104, 377-388, 387.
- lviii. Benjamin Kagwa, 1928-42, C1304, Uganda National Archives; Kagwa, *A Ugandan*.
- lix. Kagwa B - Native Student, 1939-40, CO 536/207/11, TNA.
- lx. Dr Kauntze to Dr. O'Brien, 9 March 1940, *ibid*.
- lxi. J.E.W. Flood to A.J.R. O'Brien, 27 December 1939, *ibid*.
- lxii. 'Negro Physician from Central Africa', *St. Louis Post-Dispatch*, 27 August 1940, *ibid*.; Kagwa, *A Ugandan*, 113.
- lxiii. Kagwa, *A Ugandan*, 114-5; "Manhattan Central Medical Society--N.Y.C.," *J. Natl. Med. Assoc.*, 1949, 41, 38.
- lxiv. Kagwa, *A Ugandan*, 17. On Kagwa's return see also "Dr. Kagwa Home - for Ever," *Uganda Argus*, 23 August 1963, 3.
- lxv. Rankin and Philip, "An Epidemic," 168.
- lxvi. *Ibid.*, 167.
- lxvii. *Ibid.*, 168.
- lxviii. *Ibid.*
- lxix. *Ibid.*
- lxx. On responses to lumbar punctures, see Maryinez Lyons, *The Colonial Disease: A Social History of Sleeping Sickness in Northern Zaire, 1900-1940* (Cambridge: Cambridge University Press, 1992), 84; Luise White, *Speaking with Vampires: Rumor and History in Colonial Africa* (Berkeley: University of California Press, 2000).
- lxxi. Ministry of Health Annual Report for the Year from 1st July 1963 to 30th June 1964, 16, Albert Cook Memorial Library, Kampala; Minutes of the Kigezi District Team, 6 August 1963.

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- lxxii. Minutes of the Kigezi District Team, 14 October 1963.
- lxxiii. Minutes of the Kigezi District Team, 4 May 1964.
- lxxiv. This figure may, of course, have been exaggerated. The author and research assistant were unable to locate anyone who could remember such an event.
- lxxv. Kagwa, "Problem of Mass Hysteria," 560-1.
- lxxvi. Ibid., 561.
- lxxvii. Ibid., 560.
- lxxviii. It is likely that Kagwa was influenced by psychoanalysis during his training and practice in the United States. Arthur P. Noyes and Lawrence C. Kolb, *Modern Clinical Psychiatry*, vol. 6th edn. (Philadelphia: W.B. Saunders, 1963), 430-6.
- lxxix. Kagwa, "Problem of Mass Hysteria," 565.
- lxxx. Ibid.
- lxxxi. Ibid.
- lxxxii. Rankin and Philip, "An Epidemic," 170.
- lxxxiii. Kagwa quoted from Carothers, *The African Mind*.
- lxxxiv. Kagwa, "Problem of Mass Hysteria," 565.
- lxxxv. *WHO and Mental Health 1949-1961* (Geneva: WHO, 1962), 34.
- lxxxvi. Kagwa, "Problem of Mass Hysteria," 562.
- lxxxvii. Ibid., 565.
- lxxxviii. Ibid., 562-3.
- lxxxix. See, for example, "Epidemic Hysteria," *BMJ*, 26 November 1966, 1280; George Rosen, "Psychopathology in the Social Process: I. A Study of the Persecution of Witches in Europe as a Contribution to the Understanding of Mass Delusions and Psychic Epidemics," *J. Health Hum. Behav.*, 1960, 3, 200-211; F.K. Taylor and R.C.A. Hunter, "Observation of a Hysterical Epidemic in a Hospital Ward," *Psychiatr. Q.*, 1958, 32, 821-839.
- xc. On recapitulation theory, which stressed anatomical similarities between Africans and European children, see Stephen J. Gould, *The Mismeasure of Man* (New York: Norton, 1981), 114-119.

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- xc. Robert E. Bartholomew, "Tarantism, Dancing Mania and Demonopathy: The Anthropological Aspects of 'Mass Psychogenic Illness,'" *Psychol. Med.*, 1994, 24, 281-307.
- xcii. Rankin and Philip, "An Epidemic," 167.
- xciii. Suzette Heald, *Controlling Anger: The Anthropology of Gisu Violence* (Oxford: James Currey, 1998), 245.
- xciv. DC Bugisu to District Forestry Office, 9 May 1960, Marriage, Customs, Witchcraft etc., 1943-64, MBL/4/57, Mbale District Archives [hereafter MDA]; Heald, *Controlling Anger*, 1.
- xcv. *Controlling Anger*, 229-30; Suzette Heald, "Mafias in Africa: The Rise of Drinking Companies and Vigilante Groups in Bugisu District, Uganda," *Africa*, 1986, 56, 446-467.
- xcvi. Minutes of the Security / Intelligence Committee Meeting, 10 August 1964, Homicide in Bugisu, MBL/4/68, MDA.
- xcvii. Interview MLE-06.
- xcviii. Interview with Gisu male, 71 years old, Mbale District, 27 October 2011 (MLE-11).
- xcix. Interview with Gisu female, 70 years old, Mbale District, 31 October 2011 (MLE-15).
- c. Interview with Gisu female, 80 years old, Mbale District, 27 October 2011 (MLE-09); Interview with Gisu female, 74 years old, Mbale District, 27 October 2011 (MLE-13); Interview MLE-15; Interview with Gisu male, 77 years old, Mbale District, 27 October 2011.
- ci. Pamela Khanakwa, "Masculinity and Nation: Struggles in the Practice of Male Circumcision among the Bagisu of Eastern Uganda, 1900s to 1960s" (PhD diss., Northwestern University, 2011), 53.
- cii. Ibid., 236. Circumcision year names from 1801-1970 are listed in Margaret Macpherson et al., "Circumcision Year Names (Kamengilo) in Masaba & Their Meanings," *Uganda J.*, 1980, 39, 59-75. In 1964, the age-group name was *umuinga*, referring to the appointment of Y.S. Mung'oma as the first constitutional head of Masaba (Mount Elgon). Ibid., 73.
- ciii. Interview with Gisu female, 81 years old, Mbale District, 27 October 2011 (MLE-03); Interview with Gisu female, 75 years old, Mbale District, 27 October 2011 (MLE-04); Interview with Gisu female, 60 years old, Mbale District, 27 October 2011 (MLE-05); Interview MLE-09; Interview with Gisu male, 81 years old, Mbale District, 27 October 2011 (MLE-02). Heald has noted that the Gisu describe the *basambwa*, ancestral spirits, as 'like the wind'. Heald, *Controlling Anger*, 205.
- civ. Interview MLE-03; Interview MLE-04; Interview MLE-05; Interview MLE-07; Interview with Gisu female, 80 years old, Mbale District, 27 October 2011 (MLE-08);

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- Interview MLE-09; Interview MLE-13; Interview MLE-16; Interview MLE-15; Interview with Gisu male, 80 years old, Mbale District, 27 October 2011 (MLE-01); Interview MLE-06; Interview with Gisu male, 70 years old, Mbale District, 27 October 2011 (MLE-10); Interview with Gisu male, 77 years old, Mbale District, 1 November 2011 (MLE-18).
- cv. Interview MLE-08; Interview MLE-16; Interview MLE-15; Interview MLE-10; Interview MLE-12; Interview MLE-18.
- cvi. Interview MLE-03; Interview MLE-04; Interview MLE-05; Interview MLE-07; Interview MLE-08; Interview MLE-13; Interview MLE-16; Interview MLE-01; Interview MLE-06; Interview MLE-12.
- cvii. Interview MLE-07.
- cviii. Interview MLE-02.
- cix. Jean La Fontaine, *The Gisu of Uganda* (London: International African Institute, 1959), p. 50; Jean La Fontaine, "Witchcraft in Bugisu," in *Witchcraft and Sorcery in East Africa*, ed. John Middleton and E.H. Winter (London: Routledge & Kegan Paul, 1963), 191, fn. 1.
- cx. Heald, *Controlling Anger*, 6; La Fontaine, "Witchcraft," 192.
- cxi. Parle, *States of Mind*, 157.
- cxii. Interview MLE-02.
- cxiii. For discussion of these themes, see Melissa Graboyes, "Surveying the 'Pathological Museum': A History of Medical Research and Ethics in East Africa, 1940-1965" (PhD diss., Boston University, 2010); White, *Speaking with Vampires*.
- cxiv. Interview MLE-02.
- cxv. Benjamin H. Kagwa, "Observations on the Prevalence and Types of Mental Diseases in East Africa," *East Afr. Med. J.*, 1965, 42, 673-682, 673.
- cxvi. Ministry of Health Annual Report, 1963-1964, 16, 23.
- cxvii. Kagwa, "Problem of Mass Hysteria," 561-2.
- cxviii. La Fontaine, *The Gisu*, 53.
- cxix. Susan Reynolds Whyte, "Penicillin, Battery Acid and Sacrifice," *Soc. Sci. Med.*, 1982, 16, 2055-2064.
- cxx. Interview MLE-11.
- cxxi. Ibid.

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- cxix. Interview MLE-01; Interview MLE-02. For fuller treatment of the types of ritual specialists among the Gisu, see La Fontaine, "Witchcraft," 190.
- cxiii. Interview MLE-03; Interview MLE-04.
- cxiv. Interview MLE-08; Interview MLE-09; Interview MLE-18.
- cxv. Interview MLE-05.
- cxvi. Interview MLE-13; Interview MLE-16; Interview MLE-01; Interview MLE-02; Interview MLE-10; Interview MLE-12.
- cxvii. Interview MLE-18.
- cxviii. White, *Speaking with Vampires*.
- cxix. Interview MLE-12.
- cx. Steven Feierman, "Change in African Therapeutic Systems," *Soc. Sci. Med.*, 1979, 13B, 227-284; John Janzen, *The Quest for Therapy: Medical Pluralism in Lower Zaire* (Berkeley: University of California Press, 1978).
- cxxi. John Orley, "Indigenous Concepts of Disease and Their Interaction with Scientific Medicine," in *Health in Tropical Africa During the Colonial Period*, ed. E.E. Sabben-Clare, D.J. Bradley, and K. Kirkwood (Oxford: Clarendon Press, 1980), 127. Ssekemwa gives some examples of this in J.C. Ssekamwa, "Witchcraft in Buganda Today," *Transit.*, 1967, 30, 30-39.
- cxii. Interview MLE-07.
- cxiii. Heaton, "Stark Roving Mad," 105.
- cxiv. T.A. Lambo, as cited in J.B. Loudon, "Social Aspects of Ideas About Treatment," in *Transcultural Psychiatry*, ed. A.V.S. de Reuck and Ruth Porter (London: J. & A. Churchill, 1965), 192-3.
- cxv. See, for example, *Mental Health Services in the Developing World: Reports on Workshops on Mental Health, Edinburgh (1986) and Kampala (1969)* (Hove: Hove Shirely Press, 1969).
- cxvi. See, for example, Basil Bernstein, "Social Class, Speech Systems and Psycho-Therapy," *Br. J. Sociol.*, 1964, 15, 54-64.